



Cynulliad National
Cenedlaethol Assembly for
Cymru Wales

Y Pwyllgor Deisebau

Adroddiad Cwblhad

Crynodeb o ystyriaeth y Pwyllgor Deisebau ar P-03-113 Prawf PSA

Awst 2008

Cyflwynwyd

21 Chwefror 2008

Dyfarnwyd yn Dderbyniol

12 Mawrth 2008

Ystyriaethau Cychwynnol

10 Ebrill 2008

Ystyriwyd y ddeiseb hon.

Cytunodd y Pwyllgor i:

- Wahodd y deisebwyr i roi tystiolaeth mewn cyfarfod yn y dyfodol.
- Ofyn i'r Gweinidog dros lechyd a Gwasanaethau Cymdeithasol beth yw ei safbwynt ar hyn o bryd o ran darparu sgrinio canser y brostad 'ar gais'

(Gweler Atodiad 1 ar gyfer y darn perthnasol o'r trawsgrifiad ar gyfer y cyfarfod ar 10 Ebrill 2008, ac Atodiad 2 ar gyfer y llythyr a anfonwyd gan y Cadeirydd at y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol)

Ystyriaethau Pellach

22 Mai 2008

Rhodddwyd tystiolaeth lafar i'r Pwyllgor gan y deisebwyr ac ystyriodd y Pwyllgor ymateb y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol. Yn dilyn hyn, bu i'r Pwyllgor gytuno i:

- Ysgrifennu at y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol

(Gweler Atodiad 1 ar gyfer y darn perthnasol o'r trawsgrifiad ar gyfer y cyfarfod ar 22 Mai 2008, Atodiad 3 ar gyfer ymateb y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol, ac Atodiad 4 ar gyfer y llythyr a anfonodd y Cadeirydd wedi hynny at y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol)

9 Gorffennaf 2008

Ystyriodd y Pwyllgor ymateb y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol.

Cytunodd y Pwyllgor i:

- Gau'r ddeiseb, gan na ellir mynd a hi yn ei blaen ymhellach.

(Gweler Atodiad 1 ar gyfer y darn perthnasol o'r trawsgrifiad ar gyfer y cyfarfod ar 9 Gorffennaf 2008, ac Atodiad 5 ar gyfer y llythyr a gafwyd gan y Gweinidog dros lechyd a Gwasanaethau Cymdeithasol)

**Clerc y Pwyllgor Deisebau
Awst 2008**

Atodiad 1

10 Ebrill 2008

Val Lloyd: The next petition, P-03-113, is on screening for prostate cancer.

Michael German: This is a very important issue, which I think we should get the petitioner to talk to us about. Although we may not want to deal with it ourselves, but refer it to another committee, those in the profession certainly have a range of views about whether screening is appropriate.

Bethan Jenkins: May I ask a question? Is this from the Screening Matters campaign, which we have been receiving e-mails from? I thought that the Minister had made a statement about it, but it may be totally different.

Val Lloyd: I do not think that the Minister has made a statement on this prostate cancer campaign. The Minister has made statements on breast screening, cervical screening, and bowel screening, because those are the three types of screening that are proven to be most effective.

Bethan Jenkins: Okay, I just wanted to clarify that.

Michael German: Prostate cancer is the most common cancer among men, and there is a difference of view among the medical profession as to whether screening is a good idea. I have heard eminent practitioners making the argument for both sides, and so it is a very tricky one indeed. Having the petitioner in seems to me to be a good starting point, but we may have to go a long way further with it—or perhaps another committee will have to do so.

Bethan Jenkins: Will we also ask the Minister about the current policy?

Val Lloyd: Yes, we could do that.

Andrew R.T. Davies: I think that the last line focuses everyone's mind:

'The five year survival rate of prostate cancer in the USA is 98.5%, compared with just 70% here'.

Michael German: You wait until you hear the figures—

Andrew R.T. Davies: That is why I said that the important thing is for us to get inside the issue.

Val Lloyd: That is right. There is more to this than meets the eye.

Michael German: Part of the argument, as I understand it, is that prostate specific antigen tests are slightly inexact, and so can give false—what do you call them?

Val Lloyd: False positives, and of course a false positive result would be a worry for the gentleman involved. However, let us save that discussion for outside the public

meeting.

Michael German: It should also be said that prostate cancer is likely to affect all men if they live long enough.

Andrew R.T. Davies: With my fortieth birthday this week, you have really cheered me up. [*Laughter.*]

Michael German: I only know that because I sponsored a presentation here.

Val Lloyd: It is certainly an interesting situation that needs airing. We will write to the Minister for her initial response, because we may need to write to her again after we have had evidence from the petitioners.

22 Mai 2008

12.33 p.m.

P-03-113 Profi ar gyfer Canser y Brostad ***P-03-113 Testing for Prostate Cancer***

Val Lloyd: I welcome the petitioners to the meeting—good afternoon. You have 15 minutes in total to present whatever you wish to present; how you divide that time is up to you. My introduction will not come from the 15 minutes. After those 15 minutes, the committee will have up to 15 minutes to question you, and we will then ask you to retire; you can go to the public gallery, if you wish, or you can leave the building—that is up to you. Will you first please introduce yourselves individually?

Mr Barrett: Hello, I am Norman Barrett, the chief executive of the Association for International Cancer Research.

Ms Long: I am Geraldine Long, the donor development manager at AICR.

Dr Matfield: My name is Dr Mark Matfield, and I am the scientific co-ordinator of the charity.

Val Lloyd: Thank you. If you could now give your evidence, you have 15 minutes, so please use the time in any way that you want.

Mr Barrett: The Association for International Cancer Research is a British-based charity—we happen to have our offices in St Andrew's—and we fund research into any aspect of cancer in any area of the world. We currently have 268 cancer projects in 23 different countries, two of which are based here in Cardiff. We are here to talk to you about the prostate specific antigen test for prostate cancer. We feel that it should be made available on demand to any man aged over 50. Dr Matfield will explain the thinking behind this, and why we would like this to happen.

Dr Matfield: Thank you, Norman. Would you be my assistant and run through the

slides on display as I give the presentation? This next slide simply makes the point that prostate cancer is a growing problem in the UK. These figures show the incidence per 100,000 people—that is the upper, blue line on the graph. The lower, dark blue line is the death rate. What that translates to in hard numbers in the UK is 35,000 cases of prostate cancer each year, and 10,000 deaths. So, for Wales, you are looking at just under 2,000 cases a year, and 500 men dying.

There is a test that is widely available and heavily used for this—the PSA test. We must be careful here: it is not actually a test for prostate cancer. It is a test for problems with the prostate; bacterial infections of the prostate could cause an increase in the PSA level in the blood, as could a benign enlargement of the prostate, which many elderly men suffer from. However, it is a simple test to take, involving just a couple of minutes with a nurse to take the blood, and the results can be back within two days. Sadly, it is far from an ideal test; it has a high false positive rate and a significant false negative rate. Having said that, it is, by a long chalk, the best test available. Others are being researched and tested at the moment, and we hope that, in 10 years or so, they might replace it, if they are adequately funded and are better tests. However, that is a hope on the horizon rather than a real prospect at the moment.

The key point is how much the test is used, and that is what we are here to talk about today. In America, principally because their health system is funded by insurance companies, doctors are very keen that men should take this test, and there is a high level of awareness of the PSA test in America. Figures show that about 50 per cent of men over the age of 50 have had the test, and the five-year survival rate is as close to 100 per cent as you can get, practically. In this country, the PSA test is used far less, and our five-year survival rate—that is, your chance of living five years after your diagnosis with prostate cancer—is around two thirds. It is, frankly, not good by most international comparisons.

The key is early diagnosis, and that is why testing is so important. It is a truism for all cancers that, the earlier you diagnose it, the greater your chances of survival. If you can catch a cancer before it has started spreading, it is amenable to almost 100 per cent effective treatment by surgery. Statistics in this country show how dramatic a difference that makes. Early prostate cancer is defined as not having spread outside the prostate gland; advanced is cancer that has spread, and as you can see from the slide, the difference in survival rate is enormous.

12.40 a.m.

I will now switch to talk about the policy on PSA testing. The NHS policy, which is used by the health services in Wales, Scotland and Northern Ireland as well as England, is quite simple. It says, perfectly correctly, that there is no conclusive evidence that a PSA screening programme would save lives. We thoroughly agree with this; it is a little unfortunate that this petition was labelled for you as being about PSA screening, because we are not talking about screening. Screening is a programme where the health service says that it wants to test everyone or nearly everyone in the population. We are not talking about that, and there is no strong case for doing that yet; the research to show that it would save lives has not been done. We are talking about greater availability of the PSA test for men who want it. There is a problem with this question, in that the research being done into this—two large trials in America and Europe—may not be able to provide conclusive evidence as to

whether the PSA test will save lives, because all the men taking part are having the test voluntarily, whether they are meant to or not, so it is skewing the results.

However, the NHS policy, and the same policy applies in Wales, is called the prostate cancer risk management programme. As you can see on the next slide, what it says is that it strives to:

'Ensure that men who are concerned about the risk of prostate cancer receive clear and balanced information about the advantages and disadvantages of the PSA test and treatments for prostate cancer'.

This is perfectly sensible. As you can see on the next slide, what it, sadly, does not say is what should happen after they have had that information. It says one or two things that are going in that direction. To paraphrase—there are far too many sheets of paper—it says that it is hoped that this will help men to make an informed decision about PSA testing, but it does not actually say that they can have the test. That is the problem. There is no statement anywhere in this policy that says that, if a man decides that he should have a test, he has any influence on the decision.

As you can see on the final slide, we are not suggesting that there should be a PSA screening programme, but simply that if a man decides, having received the information, that he would like a test, he should be able to have one. By this, we are talking about men who are aged over 50. Men need information to help them to make this decision; it is not a simple question. Their GPs are the ideal people to help them with that information, but, in our view, it is men who should make decisions about a key test for their health, not their doctors. This is a situation where men should have power in their own hands, because opinions differ among doctors, and we get far too many letters from men who say, 'I think that I should have a test, but my doctor would not give me one'. We do not think that that is right. On something like this, men should decide.

We have made this pitch to many organisations, and what tends to happen, as happens here, is that the Ministers and health departments give the easy answer, namely saying that PSA screening is not appropriate. Let me emphasise again that we are not talking about that. In a nutshell, we are asking that someone, somewhere in the UK, in just one part of this country, starts this ball rolling and starts doing what they do in America, parts of Australia and many parts of Europe, namely give the PSA test on demand to men aged over 50. Our pitch to you is that Wales should be the place to start this. You can start the ball rolling and the rest of the country will follow you.

Val Lloyd: Thank you. Miss Long, did you want to contribute at all?

Ms Long: No, that is fine.

Val Lloyd: What about Mr Barrett? You are within time.

Mr Barrett: I just want to say that we are trying to get parity between prostate cancer and breast cancer. The fact that 10,000 men a year are dying is bad enough in itself, but Geraldine and I have members of our families who have died of prostate cancer.

In both cases, they had secondary cancers, because it had not been diagnosed early enough. One thing that troubles me greatly about this is that, whether the test is as good as it could be is immaterial, prevention is better than cure. So, the earlier we detect this, even if we get some false readings to start with, and the sooner we pick up that there is cancer there, the better the chance of no secondary cancers developing at a later stage. Therefore, it is important that this goes forward.

With 10,000 deaths, the initial idea was to try to get 10,000 signatures on a petition to present to the Government to say, 'This represents the number of deaths from this each year; please make this available on demand and give the additional information that is needed'. We are taking this to our own website, we have a petition on the 10 Downing Street website, we have come to speak to you, and we are attempting to do the same thing in Scotland.

Val Lloyd: Thank you, Mr Barrett and Dr Matfield. I will now open it up to questions.

Jenny Randerson: Thank you very much for that powerful evidence. Like you, I know people who have prostate cancer and I do know someone for whom the test has proved absolutely pivotal, so I understand the importance of it. You have very powerful evidence, and very striking indeed is the statistic from the USA. I have to play the devil's advocate here. Are there any other factors in the USA that could explain the strikingly high survival rate?

Dr Matfield: Yes, without a doubt. The Americans have a much more aggressive approach to the treatment of prostate cancer. The statistic that we showed there is the most well known and the most striking, but, if you were being critical, you would look at the best evidence on this type of cancer, which probably comes from studies in Australia, where different Australian states have different policies on the prostate-specific antigen test but, effectively, the same approach to treatment. There is a 30 to 40 per cent difference in five-year survival rates there just because one state has a policy on testing whenever it is appropriate and another has no policy at all. So, it tends to be ruled by health economics more than anything else. I should actually say that the PSA test is incredibly cheap: it costs just £12 per test.

Jenny Randerson: The cost per test was going to be my second question, so thank you very much for answering that.

Bethan Jenkins: I want to ask about the research that has been done on the fact that many of the men tested who have high levels of PSA find that they do not suffer from prostate cancer, although they have to go through the process of having a biopsy, which puts pressure on them. Do you believe that the benefits of having the test outweigh that stress, and that they should be able to receive the test regardless?

Dr Matfield: Yes, we do, because the picture that tends to be painted—that a high PSA count does not necessarily indicate that you have cancer—is an oversimplification. The normal count in men up to 80 years of age ranges between 0 and 5, and so if a man in his late 70s presents and has a PSA count of 10, that is something to watch but not to get massively alarmed about. If his count is more than 20, which is usually the upper range of benign conditions that can cause a raised PSA count, like the standard enlarged prostate that so many old men have, you would then start to look for another argument. Is there perhaps some bacterial

infection? Why is the PSA raised? If he were to present with a PSA of 50, alarm bells should be ringing. That man probably has metastatic prostate cancer already, because nothing else can produce a really high PSA reading unless he has been in a car accident or suffered another sort of traumatic injury.

So, there is a range of sets of information that you can get from the PSA level. If it is middling, you would say, 'Come back in a month and we will do another one'. If you find a sustained high level, you know that it is not a one-off thing like an infection. Even vigorous exercise can sometimes cause a slight raise in the PSA count, so you look for a sustained level. If the cancer is progressing, you look for an increasing level and then, based on that, you, as someone treating that man, would make a decision about what tests would be appropriate next. The test is not all or nothing, 'Bang, this says he has or has not got cancer'; it tells you whether more testing is required. Typically, the next test would be a transrectal ultrasound, which gives you quite a good image of the prostate gland and so you can actually see any tumours in it.

Bethan Jenkins: You say that it is an oversimplification, but that is the advice from the UK National Screening Committee. Do you believe that it has oversimplified the arguments as well?

12.50 p.m.

Dr Matfield: There is no doubt that there are divided opinions about the PSA test among GPs. However, you will find that GPs in countries and areas where it is used are convinced of its value. The problem is that many of the GPs, committees and Governments that look at this have a mixed set of concerns and criteria on their agenda. If you read the full advice to GPs, you get the flavour that they are concerned about trying to hold the fort against the demand that would cost them a lot of money if a screening programme were instituted. Cost is an issue for them, but I think that that is a poorly informed view. The whole point of spending money in the health service is to save lives, to be frank. That is what it is there for.

Val Lloyd: Have you finished that line of questioning, Bethan?

Bethan Jenkins: Yes.

Val Lloyd: You said that it costs £12 per test. Have you had any indication of the demand were that to be made available on request? Have you explored the potential take-up in any way, or do you have any research that would indicate what the take-up would be?

Dr Matfield: No, and I am not sure how one could do rigorous research into that. We can give you anecdotal evidence, certainly, because we have put a lot of effort into communicating with our supporters. Through direct-mail campaigns, we are in regular touch with 0.25 million men in the UK to say, 'You should look at this'. The number of letters that we get back, either saying, 'Okay, I thought that this was useful, because it showed me that I am okay and that is a relief', or saying, 'It showed me that I was not okay, so thank you for saving my life', indicates to us that there is a significant interest in taking this up among men aged over 50, and that that interest gets greater as men get older.

Ms Long: I deal daily with donors, and we get a great many letters because we put a lot of emphasis on prostate cancer through our Spotlight Appeal for prostate cancer research. We get letters from supporters who say that their GP would not offer them the prostate-specific antigen test, so they had to go private or move to another health board area where they could get the test.

The PSA test is just the first step on a diagnostic pathway, very much like the mammogram. A mammogram will not tell you that you have cancer; it will tell you that something needs further investigation. I am not saying that the test will diagnose cancer, but there will always be the other follow-up examinations, such as digital examinations, ultrasound and biopsies, just as there are for every other cancer. The test is the first line of investigation, and it will show up a problem.

Bethan Jenkins: Have you talked to GPs about the effect of the guidance that is given to them, about how widely distributed it is among men registered with their surgeries, or about the level of take-up as a result of the guidance?

Dr Matfield: We have not done that, and we would hesitate to do so. It would be perceived as being critical of GPs' practice or of the information provided. When I went to see my GP about this, I was not offered any information. I do not know whether you were.

Mr Barrett: No, I was offered no information either, but I was told that I could have the test. Other than that, there was nothing forthcoming.

Part of the problem with this is that prostate cancer is not spoken about in the same way as breast cancer is spoken about for women. So, women are much more aware of the situation, and probably go for tests and check themselves. You cannot check for prostate cancer without having some kind of internal test, so really the PSA is the first start. This is as much about trying to get men to be more aware of their health, which is a difficult thing to do in itself. Raising the profile of the test and telling men that it is available so please go and have it is the starting point. Surely, in the longer term, the earlier you are diagnosed as having this cancer, the better your chance of surviving that and any secondary cancers. That is the fundamental point that will save money for the health service in the longer term by preventing rather than trying to cure the disease. In all of this argument, that is one thing that appears to be missed. People are always talking about costs and the fact that it costs a lot of money to screen in this way. My attitude is that you also have to measure the cost in the longer term of having to provide treatment.

Andrew R.T. Davies: Thank you for your evidence this morning. As the only male Assembly Member present, I read it with interest, although I seem to be the right side of 50 at the moment, but I appreciate that cancer does not discriminate on grounds of age.

In the evidence—and you highlighted this, Mark—you are not calling for a screening policy. It says here, in bold print, that, nationally, the Government is against any screening policy using the PSA system, because it is not as accurate as it could be. So, what you are saying to us is that it should be an option for people who go to the GP, and the Government should not be compelled to provide a national screening campaign in Wales, as the option should be explored by a patient visiting their GP.

Mr Barrett: At the moment, there are GPs out there who say 'no' to such requests.

Dr Matfield: One could go further about the screening point. There is a well defined set of criteria which needs to be fulfilled before you put a screening programme in place. You have to know that it will save lives, the test must have a certain level of accuracy and you must know something about the course of the disease. The PSA test for prostate cancer falls down and fails to meet several of those criteria. Even if the PSA test got better, I do not think that there would be a case for the screening programme. So, the screening programme is out of the window. This is about the availability of the test if a man decides that he should have it.

Val Lloyd: At the moment, some GPs will give the test if you go to them, or, if they have reason to think that it may be needed, they would allow you have it, but that is not a universal policy. Is that the same across the four UK countries?

Mr Barrett: Yes.

Dr Matfield: We receive hundreds of letters from all over the UK, including Wales, some of which say, 'I went to have the test, and I got it with no problem', and others that say, 'Oh, we do not do that here'.

Andrew R.T. Davies: The USA figures are very compelling, but, from my limited understanding of cancer treatment in the UK, as you rightly highlighted, it is very aggressive with treatment and the level of cancer care is exceptional, in many instances. How would we compare on a European basis, which is a far closer comparator? Interestingly, the figures about what is going on in mainland Europe were not supplied.

Dr Matfield: The answer is that we are roughly in the middle of European survival rates for prostate cancer, but I am not sure that the comparisons are that much more informative. For example, in France, which I know very well, the health system is superb. It is enormously well funded, to the point at which the French say that it is bankrupting the country. If you wanted to have an x-ray, you would get your typed-up results from the doctor in 45 minutes, but that is because a lot of money is pumped into the system. Health services are like anything else: you get what you pay for. The cancer care in France is very good, but, in other parts of Europe, where less is invested in the health service, or where the geography goes against it because it is a large country with a low population density, the survival rates are lower, because there is not the same level of investment and there are not as many hospitals. So, there are marked differences in health services across Europe, which give marked differences in survival rates.

Andrew R.T. Davies: That is a bigger argument regarding how health services operate on the continent, especially the French model. Moving on to some of the variables in the testing system, some of the figures that I have seen show that the PSA test can throw up around 20 per cent of false results, but enormous amounts of research are being done to try to bring that variable level down. How far down that road are we of getting a PSA, or whatever, to be more accurate in its testing? From the papers that I have read, it seems that people are holding off for a better system to come through.

Mr Barrett: We are a long way from that—up to 10 years. To be frank, let me put it to you in a different way. I lost my grandfather to this disease, and so it is very personal to me. I recently turned 50, and I have now asked for the test. From my perspective, I ask myself, which situation would I rather be in? Would I rather have the test, which says that I have a problem, get it checked again, and it still says that I have a problem, so then I have the next two or three stages of treatment, only to be told that I have it but it is not in an area that I need to worry about, and so I can go 'Phew, although that was a bit worrying', or would I rather not do anything for the next 10 years, and then suddenly find that I have a major problem as I have cancer that it is quite far advanced, there are secondary cancers, and it has spread to this, that and other parts of my body, and so my chances of survival over the next five years are zero?

1.02 p.m.

I know which answer I would rather have and that for me is the point because we are not saying that we should spend huge amounts of money and ensure that everyone does it; we are saying, 'Let us inform people and tell them that the test is available and let us say to them that if they want to have the test and to start the process, then this is it. Yes, these are the shortcomings, but at least you are doing something about it, and taking a more involved view of your own health.'

Andrew R.T. Davies: I am going to ask you to state the obvious now, given what you have just said, but how can the other bodies that regulate this justify their position that states the exact opposite, namely that we should stand back and wait until a better test comes into existence? As I said, I have read papers that present the other side of the coin. Your argument is compelling, but—

Dr Matfield: With respect, they are arguing about prostate-specific antigen screening—

Val Lloyd: Could you be brief please, because we are now out of time.

Dr Matfield: They are talking about PSA screening and not about the availability of the test. In terms of screening, their argument is good, but that is not what we are talking about—we are talking about making the test more available.

Val Lloyd: I am sorry, but we have run out of time now. Your evidence was very interesting and there were further questions, but we keep to a 15-minute limit so that all petitioners have exactly the same care and attention. Thank you for answering the questions. While you go to the public gallery to hear our deliberations, we will move to the next item and then return to yours so that you can hear our discussion in full.

Val Lloyd: We will now go back to the first petition on the availability of the PSA test. I think that the petitioners are safely up in the gallery, so it is now over to Members to comment.

Bethan Jenkins: On the flip side of saying that the test is available and that it would not incur costs is the fact that some general practitioners are not implementing it

because of the quality of the test, which is the advice that they have been provided. If the screening committee believed that the test was effective, there would be an argument for them to say, 'Of course we will roll it out', and that GPs would be told to provide testing on a streamlined basis across the board. However, because there are issues arising from the test, they have decided not to do that. So, I would say that we should ask the Minister again to clarify her position on this, in light of the information that they just want to have a comprehensive availability of the test, as opposed to rolling out the test across Wales.

Val Lloyd: I think that that is the point at issue, because, clearly, as Dr Mark Matfield said himself, it does not meet the requirements in the national screening programme, but the petitioners' wish is to have it available on request. Of course, that raises the issue that, once it becomes publicly known that it is available, requests for the test are bound to increase, but that is not for us to decide. It would be right for us to write to the Minister to ask for her views on this and whether she would consider putting that in guidance to local health boards in order for them to give guidance to GPs. Do you agree?

Andrew R.T. Davies: The point that we need to make, which was made forcibly to us, is that we are not looking at the screening side of it, which, from the weight of evidence that I have seen, is where the focus has been, but at availability, which is what the petition itself requests. I endorse everything that Bethan said—it is about availability and choice at the end of the day, and guidance on that needs to emanate from this institution. At £12 a test—

Bethan Jenkins: That is why there is a contention about making it available—because of the disparities in the evidence. That may be what will come back from the Minister, but it may not and it may be different.

Val Lloyd: It is not precisely comparable with mammograms, but the availability issue is similar. There is a screening programme; because it has various outcomes, if you are worried or you spot a lump, you can go to your doctor and a mammogram is available. However, that does not quite apply here, and the doctor would also need to give advice to the patient about the potential false positive results and otherwise. I think that we must, as a committee, write to the Minister.

Jenny Randerson: I am pleased that you drew that parallel, Val, because, of people recalled for further tests following a mammogram, four out of five do not have cancer. That is a similar scenario really; it is not a false positive in the same way, but getting a positive test on the mammogram does not mean that you have cancer, but that you need further tests. Once again, it is the same situation that we see so often—spend a bit of money now and you save a great deal of money as well as many lives later. I think that we should write to the Minister, but I completely support Andrew's comment that we need to make it clear that we are not asking for screening in the traditional sense, which was the misinformation that we had in our minds. We might also suggest to the Minister that she consider other approaches to increase the numbers of men who take this test and the number of GPs who are prepared to offer it. Perhaps we can suggest that it be looked at in relation to instructions to GPs, guidance to GPs, and even the GP contract and the quality and outcomes framework.

Val Lloyd: Fine. I believe that we have pretty universal agreement. We accept that this is not a screening programme, but we are going to ask the Minister to look at it across the piece, as we described.

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Janice Gregory: We will now move on to number six, the availability of the prostate specific antigen test. You will have seen the response from the Minister for Health and Social Services to the prostate specific antigen test for men over 50. Having read it, it is not just a simple blood or urine test, where you would just get a positive or negative result. It seems to be far more complex than that. I believe that the Minister's letter sets that out clearly. What is crystal clear to me is the fact that this test is available. If someone asks for it—perhaps because of family history—the GP would need to make the patient aware of just how complex the results can be. I do not know how Members feel about that—does anyone wish to comment?

Bethan Jenkins: The only issue that I have is that I do not believe that it is different to when we first wrote the letter to the Minister regarding the fact that they wanted it on demand. I believe that they already knew from the first letter that that was Government policy, which is the same policy as the Westminster Government. I know that the petitioners are not going to be pleased with this, because they were saying that they wanted it to be initiated differently to the current policy.

Kirsty Williams: My understanding—not that I was here for previous discussions—is that there is a campaign to institute a screening service in the way that we would understand other cancer screening services, whether for breast cancer, cervical cancer, or, potentially, bowel cancer. Is that what they wanted?

Mr Sanchez: No, we had a discussion with the petitioners at an early stage, and they made it clear that this was not about screening.

Kirsty Williams: Oh, right.

Andrew R.T. Davies: They came to committee and gave us comprehensive evidence.

Mr Sanchez: We had included some public papers. I think that we had called it screening for prostate cancer, and they were particularly unhappy about that. They made the clear point that it was not about screening.

Andrew R.T. Davies: This is the initial stage; you then go on to have the screening.

Janice Gregory: I am in the same position as Kirsty, or a worse position, because I only know what I have read, and from speaking to the clerk. It appears to me that, some people who present to a GP because of family history, or whatever, feel that, having reached the golden age of 50, they would like this test. However, it is not refused to them—it is just that it is not like a normal mammogram, where you go and have a mammogram, and, if something is discovered, you then go on. There seems to be a far more complex explanation of tests—it does not just come back when something is raised, and you need further tests; it is complex. That could perhaps make it a more anxious time.

Kirsty Williams: I have not heard previous evidence, but I have read the papers, and from my previous membership of the health committee, as well as in a Welsh Liberal Democrat policy context, I have had many discussions on PSA. The issue is that, in managing someone with a raised PSA level, you have to watch for weighting and for false-positives, but how do you identify an individual who, potentially, has a form of prostate cancer? Is it an aggressive form that will need aggressive treatment, or is it a kind of cancer where you can sit back and monitor it and wait? You are right that the PSA issue is not as straightforward as it first appears. There is different advice on this, and different medical opinion about the appropriateness of the use of PSA and what you do afterwards. Any potential treatment arising out of this is radical, and could, potentially, have significant side-effects, as I understand it.

Andrew R.T. Davies: I suppose that that is the danger of the petition process—we sometimes take evidence before the other correspondents catch up with it. However, we received a graphic, professional presentation. My understanding of the petitioners' request is that the test was more readily available; rather than the patient initiating the test, it was the health professional initiating the test, as a matter of course. Forgive me if I am misconstruing that. Therefore, the request was that the health establishment in Wales adopt this test as a matter of course, rather than as a matter of request from the patient. As they were saying, it is not the screening process—this is very much the initial diagnosis, to see whether you should go on for further screening, and so on. We are fortunate that we had Mike German here last time, who is an expert on this issue, because he had taken a lot of evidence on it in a previous policy forum or something.

9.40 a.m.

Kirsty Williams: We had a big Liberal Democrat debate about offering PSA screening as a manifesto commitment, but it was rejected at conference.

Janice Gregory: The difficulty is that we know that the test is available and that GPs would be required to ensure that patients understood exactly what could come back from the test. However, Andrew is saying that what the petitioners wanted was for the test to be offered. I would have thought that if a GP—for example, my GP, who is incredibly thorough—had any concerns or suspicions, he or she would offer this test anyway as part of the patient's care.

Bethan Jenkins: The petitioner was saying was that that is not happening on a routine basis across Wales.

Andrew R.T. Davies: There is good practice and there is bad practice. The Minister has made it clear in her letter that the test is available, but that she has no current plans to change the process. We, as a committee, cannot instruct the Government to change its plans. The petitioners have brought their persuasive argument here, but, at the end of the day, someone has to make a decision, and it is the Government that is charged with making that decision. Therefore, I do not see how we can advance this petition any further, because the Government states in this letter from the Minister that it has no plans to change its advice, or provide any new advice, to GPs at this stage.

Kirsty Williams: It seems that the Minister has taken steps to make GPs aware of the test and has offered advice to GPs. It is not for the Petitions Committee to begin to micromanage the practice of individual GPs.

Andrew R.T. Davies: Or the NHS in Wales.

Kirsty Williams: There may be other avenues by which people, if they are unhappy with practice, could pursue that at a local level, via the community health council or via the local health board's director of primary care. There may be a need to issue additional guidance on a local basis.

Bethan Jenkins: I only raised this because I try to see how we can best help petitioners to get through their process, but I do not believe that the Minister will change her mind or will change anything until the UK National Screening Committee—

Andrew R.T. Davies: Chair, in light of the Minister's response, I propose that we close the petition.

Janice Gregory: Okay. I am quite positive that the Minister will look at the issue again once she receives the information.

Atodiad 2

Y Pwyllgor Deisebau

Petitions Committee

Edwina Hart AM
Minister for Health and Social Services
Welsh Assembly Government
Cardiff Bay
CF11 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

Our ref: PET-03-113

18 April 2008

Dear Edwina

PETITION - TO MAKE THE PSA TEST AVAILABLE FOR ALL MEN OVER 50 TO REDUCE MORTALITY FROM PROSTATE CANCER

The Petitions Committee considered this petition for the first time on 10th April. The petition calls for the PSA test to be made available for all men over 50 and asserts that:

- Evidence from around the world shows that wider use of the PSA test is associated with higher prostate cancer survival rates
- Men in the UK who are concerned about their prostate have no automatic right to the test
- The five year survival rate of prostate cancer in the USA is 98.5% compared to 70% in the UK

Committee members are aware that this is not a black and white issue, and that there are contrasting expert opinions regarding the efficacy of this test, however, the Committee resolved to invite the petitioners in to present their case. It would therefore be helpful to the Committee if you could provide us with an outline of current Assembly Government policy regarding prostate screening and use and availability of the PSA test in particular.

I look forward to your response.

Yours sincerely,



Val Lloyd,
Chair, Petitions Committee


Atodiad 3

Edwina Hart AM MBE
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Our ref: EH/02085/08
Your ref:

Val Lloyd AM
Chair
Petitions Committee
National Assembly for Wales
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RECEIVED
07 MAY 2008

APSD

6 May 2008

Dear Val

Thank you for your letter of 18th April on behalf of the Petitions Committee, requesting the Assembly Government's policy position regarding prostate cancer screening and availability of the Prostate Specific Antigen (PSA) test.

As all screening involves potential benefit and harm the National Screening Committee (NSC) advises the for UK countries about all aspects of screening policy and supports implementation. When considering population screening programmes, the benefits and harm must be assessed carefully, and the benefits should always outweigh the harm. I must be guided by the NSC's recommendations, which are clear, that population screening for prostate cancer, including the use of PSA as a screening test, should not be provided by the NHS or offered to the public until there is new evidence of an effective screening technology for prostate cancer.

EW

Atodiad 4

Y Pwyllgor Deisebau

Petitions Committee

Edwina Hart AM
Minister for Health and Social
Services
Welsh Assembly Government
Cardiff Bay
CF99 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

Our ref: PET-03-113

5 June 2008

Dear Edwina

PETITION – PSA TEST

Thank you for your response to my previous enquiry, on behalf of my Committee, regarding the availability of the Prostate Specific Antigen (PSA) test for men over 50.

On 22 May, the petitioners (the Association for International Cancer Research) presented evidence to the Committee. The petitioners made it clear that they are not asking for the introduction of a prostate cancer screening programme, and clearly appreciate that the PSA test is just one tool that can assist in the diagnosis of a prostate problem. They consider men should have an informed choice regarding the PSA test and are asking you to consider allowing men over 50 to receive the test on demand.

In England, an informed choice approach is taken through the NHS's Prostate Cancer Risk Management Programme. The Committee agreed to ask you for details of the guidance you have issued to Welsh GPs on providing the PSA test, and whether you have any plans underway to change this.

In addition, the Committee agreed to ask whether you have considered any other approaches to encourage men to take the PSA test, and to encourage more GPs to offer the test.

I look forward to your response, and thank you for your continued consideration of this issue.

Yours sincerely,



**Val Lloyd,
Chair, Petitions Committee**

Atodiad 5

113

Edwina Hart AM MBE

Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Our ref: EH/02840/08
Your ref:

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26 June 2008

Dear Val

Thank you for your letter dated 5th June about the availability of the Prostate Specific Antigen (PSA) test for men over 50.

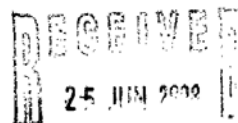
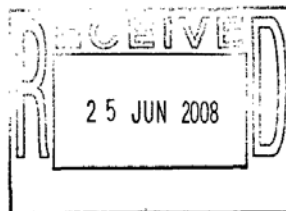
There is no restriction on access and a patient can ask their GP for the test. What is important is that men should make an informed choice concerning this test and the GP must give clear advice as the results are complex and must be interpreted properly so that the patient is able to make a properly informed choice. Access is not restricted but professionals must ensure that patients understand exactly what a test result can tell them.

All GPs in Wales have received an information pack to assist them in counselling men who enquire about the test. The pack is designed to provide information on the benefits and limitations of the PSA test. Further detail can be found at www.cancerscreening.nhs.uk/prostate/pcrm-aim

In addition to this, guidance is also available to GPs in Wales via an online decision support tool for men who are considering taking a PSA test. This was developed by researchers at Cardiff, Swansea and Oxford Universities, funded by Cancer Research UK and Department of Health. This tool is available at www.prosdex.com/index_content

I have no plans to change or provide any new advice to GPs at this stage. If the National Screening Committee reviews its advice and amends its recommendation in respect of prostate cancer then I will consider that advice.

Edwina Hart



AGD

